

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

*Description provided on attachment.

TN No. 86-9
Supersedes
TN No. 81-11

Approval Date 3-19-87

Effective Date 10-1-86

HCFA ID: 0140P/0102A

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☐ With limitations*

- 2.a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☐ With limitations*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic *which are otherwise covered under the plan.*

☒ Provided: ☐ No limitations ☐ With limitations*

3. Other laboratory and X-ray services.

☒ Provided: ☐ No limitations ☐ With limitations*

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☐ With limitations*

- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

☒ Provided

- c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 91-19

Supersedes

TN No. 90-7

Approval Date

1-21-92

Effective Date

11-1-91

HCFA ID: 7986E

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided ☐ No limitations ☐ With limitations

Revision: HCFA-PM-93-5 (MB)
MAY 1993

ATTACHMENT 3.1-B
Page 2a
OMB NO:

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP(s): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: No limitations With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations With limitations:

*Description provided on attachment.

TN No. 93-011
Supersedes 93-007 Approval Date 8-20-93 Effective Date 4-1-93

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☒ Provided: ☒ No limitations ☒ With limitations*

b. Optometrists' Services

☒ Provided: ☒ No limitations ☒ With limitations*

c. Chiropractors' Services

☒ Provided: ☒ No limitations ☒ With limitations*

d. Other Practitioners' Services

☒ Provided: ☒ No limitations ☒ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☒ No limitations ☒ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 86-9
Supersedes
TN No. 81-11

Approval Date 3-19-87 Effective Date 10-1-86

HCFA ID: 0140P/0102A

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.

☒ Provided: ☒ No limitations ☒ With limitations*

9. Clinic services.

☒ Provided: ☒ No limitations ☒ With limitations*

10. Dental services.

☒ Provided: ☒ No limitations ☒ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Occupational therapy.

☒ Provided: ☒ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

☒ Provided: ☒ No limitations ☒ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Dentures.

☒ Provided: ☒ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 86-9
Supersedes
TN No. 84-11

Approval Date 3-19-87

Effective Date 10-1-86

HCFA ID: 0140P/0102A

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Prosthetic devices.

☐ Provided: ☐ No limitations ☐ With limitations*

d. Eyeglasses.

☐ Provided: ☐ No limitations ☐ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services,
i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Screening services.

☐ Provided: ☐ No limitations ☐ With limitations*

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations*

d. Rehabilitative services.

☐ Provided: ☐ No limitations ☐ With limitations*

14. Services for individuals age 65 or older in institutions for mental
diseases.

a. Inpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Skilled nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 86-9
Supersedes
TN No. 81-11

Approval Date 3-19-87

Effective Date 10-1-86

HCFA ID: 0140P/0102A

State/Territory: IDAHO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☒ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☒ With limitations*

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☒ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☒ With limitations*

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☒ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☒ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 86-9
Supersedes
TN No. 81-11

Approval Date 3-19-87

Effective Date 10-1-86

HCFA ID: 0140P/0102A

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations*

___ Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

___ Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

___ Provided: ___ Additional coverage ⁺ ⁺⁺

- b. Services for any other medical conditions that may complicate pregnancy.

___ Provided: ___ Additional coverage ⁺ ⁺⁺ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

___ Provided: ___ No limitations ___ With limitations*

___ Not provided.

- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 94-014
Supersedes _____ Approval Date 10-26-94 Effective Date 10-1-94
TN No. 94-008

State/Territory: Idaho

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- ☐ Provided: ☐ No limitations ☐ With limitations*
☐ Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- b. Services of Christian Science nurses.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- c. Care and services provided in Christian Science sanatoria.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- d. Skilled nursing facility services provided for patients under 21 years of age.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- e. Emergency hospital services.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
- ☐ Provided: ☐ No limitations ☐ With limitations*

TN No. 87-4
Supersedes _____
TN No. _____

Approval Date 1-8-88

Effective Date 7-1-87

HCFA ID: 1042P/0016P

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DECEMBER 1994

ATTACHMENT 3.1-B
Page 9

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided ☐ Not Provided

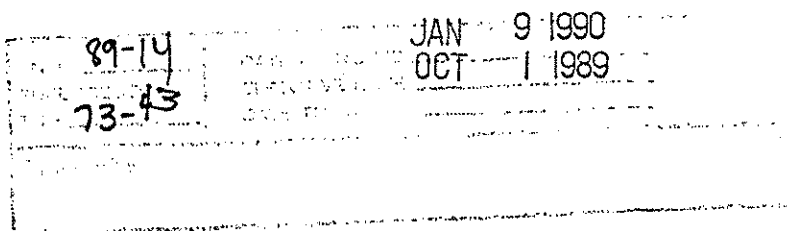
25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☐ Provided: ☐ State Approved (Not Physician) Service Plan Allowed
☐ Services Outside the Home Also Allowed
☐ Limitations Described on Attachment
☐ Not provided.

TN No. 95-002
Supersedes 93-007 Approval Date 3-29-95 Effective Date 1-1-95

Attachment 3.1-C

- (d) Standards established and methods used to assure high quality care:
1. Practitioners will be licensed by the State.
 2. Medical institutions will be licensed by the State.
 3. Any individual eligible for Medical Assistance under the plan may obtain the services available under the plan from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization which provides such services or arranges for their availability on a pre-payment basis.
 4. The scope of services and care offered under the plan includes the use of specialist and consultative services.
 5. Quality of care for hospitalized individuals will be monitored by a contract P.R.O.
 6. The Medical Care Advisory Committee at frequent intervals will review reports of care and services provided and make suggestions to the Department and to the disciplines or facilities involved concerning the quality and utilization of the care and services offered or needed.



Attachment 3.1-D

- (c) The State agency will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made for the least expensive mode available which is most appropriate to the recipient's medical needs. Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

TN # 96-004 Approval Date: 4-26-96
Supersedes
TN # 73-43 Effective Date: 4-1-96

Revision: HCFA-PM-87-4 (BERC)
March 1987

Attachment 3.1-E
Page 1
OMB No. 0938-0193

State/Territory: Idaho Dept Health & Welfare

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Pursuant to the provisions of subsections 16.03.09.081 of the State's Rules Governing Medical Assistance, the Department may purchase organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers. Individuals under twenty-one (21) years of age qualifying under the State Plan in Attachment 3.1-A.4.b.vi.k., which describes waivers in coverage exclusions for EPSDT, may receive single or double lung, or combined heart-lung transplants from Medicare certified transplant centers.

TN#: 01-002

Approval Date: 4-9-01

Supersedes TN#: 95-008

Effective Date: 4/1/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Idaho

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

☒ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☐ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

☐ Yes

☐ No

2. ☐ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

☐ Yes

☐ No

3. ☒ All individuals eligible under the State's approved title XIX plan.

☐ B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

☐ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. ...if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-\$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

IN No. 87-4
Supersedes
TN No. 74-27

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